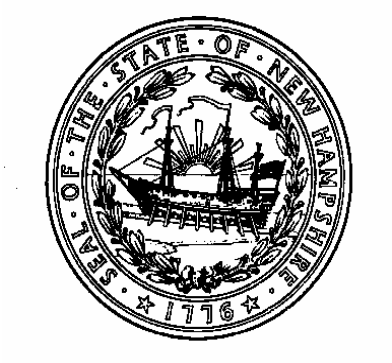
STATE OF NEW HAMPSHIRE



OFFICE OF THE ATTORNEY GENERAL

SEXUAL ASSAULT:
An Acute Care Protocol
For Medical/Forensic
Evaluation

Fourth Edition, 2005

HISTORY OF THE NEW HAMPSHIRE SEXUAL ASSAULT PROTOCOL PROJECT

On April 26, l988, the New Hampshire Legislature passed a law which made the State responsible for the payment of forensic medical examinations of sexual assault victims when there is no insurance (see Appendix A). It also authorized the Department of Justice to establish a standardized sexual assault protocol and evidence collection kit to be used by all examiners and hospitals in the State.

In 1989, the New Hampshire Attorney General's Office formed the Sexual Assault Protocol Committee representing the medical, legal, law enforcement, victim advocacy and forensic science communities, to establish a New Hampshire protocol and kit. The Committee took great care to make recommendations based upon the physical and emotional needs of the sexual assault victim, reasonably balanced with the basic requirements of the legal system.

The result was the publication of *Sexual Assault: A Protocol for Medical and Forensic Examination*, and a standardized evidence collection kit to be used in all of the hospitals in the state. This Project was completed in June 1989. A revised second edition was published in 1997.

In 2002, recognizing the significant changes in forensic evidence collection, and under the leadership of the Sexual Assault Nurse Examiner, Jennifer Pierce-Weeks, the Protocol *Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation, Third Edition 2002* was published.

Because forensic science is a field in continual evolution, it is anticipated that changes will continue to be made to the protocol in an effort to improve evidence collection outcomes for patients who have experienced sexual assault. The following is an up-to-date list of protocol revisions:

- *Sexual Assault: A Protocol for Medical and Forensic Examination*, First Edition 1989
- *Sexual Assault: A Protocol for Medical and Forensic Examination*, Second Edition 1997
- *Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation, Third Edition 2002*
- *Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation, Fourth Edition 2005*

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PREFACE

To maximize the continuity of care for patients who have experienced sexual assault, medical professionals, in concert with other professionals who care for victims of sexual assault in New Hampshire, have developed the following approach to assist New Hampshire's medical community in the care of patients reporting an acute sexual assault.

INTRODUCTION

According to the American College of Emergency Physicians, "appropriate management of the sexually assaulted patient requires standardized clinical evaluation, and effective interface with law enforcement for the handling of forensic evidence, and coordination of the continuum of care with a community plan. Appropriate management of the sexually assaulted patient requires the clinician to address the medical and emotional needs of the patient while addressing the forensic requirements of the criminal justice system. Medical issues include acute injuries and evaluation of potential sexually transmitted infection and pregnancy. Emotional needs include acute crisis intervention and referral for appropriate follow-up counseling. Forensic tasks include thorough documentation of pertinent historical and physical findings, proper collection and handling of evidence and presentation of findings and conclusions in court." *

This document seeks to assist the medical professional in accomplishing the above tasks and meeting the standard of care requirements.

**The Evaluation and Management of the Sexually Assaulted or Abused Patient*, ACEP 1999.

NEW HAMPHIRE'S SEXUAL ASSAULT AND RELATED LAWS

New Hampshire basic statutes prohibiting sexual assault are contained in the criminal code under RSA 632-A. This set of laws can be broken down into three basic criminal violations: Aggravated Felonious Sexual Assault, Felonious Sexual Assault and Sexual Assault. These three crimes all have different elements, or parts, that the state must prove when bringing a charge. These crimes also differ in the penalties available if a person is convicted of violating them.

AGGRAVATED FELONIOUS SEXUAL ASSAULT (AFSA)

This is the most serious of the sexual assault crimes. It carries a maximum penalty of 10-20 years in state prison. There are three ways in which a person can commit AFSA:

1. Sexual penetration accomplished under an aggravating circumstance: This variety of AFSA requires the State to prove that the perpetrator engaged in sexual penetration with the victim under one of several aggravating circumstances.

Sexual penetration has a broad definition, encompassing intercourse as well as fellatio (oral stimulation of the male genitals), cunnilingus (oral stimulation of the female genitals), anal penetration, digital penetration, any intrusion, however slight, into the genital or anal opening of the victim or actor and any act which forces the victim to engage in penetration with another.

Aggravating circumstances that make penetration a crime include the following:

- **Force** - Penetration accomplished through the actual application of physical force, physical violence or superior physical strength.
- **Helpless victim** - Penetration accomplished when the victim is physically helpless to resist.
- **Threat of force** - Penetration accomplished under threat of force, whether actual force is used or not.
- **Threat of retaliation** - Penetration accomplished through threat to retaliate.
- **Kidnapping** - Penetration accomplished under circumstances involving kidnapping or false imprisonment.
- **Drugged victim** - When the perpetrator, without knowledge of the victim, administers a substance to the victim that mentally incapacitates him or her.
- **Medical treatment or therapy** - When the perpetrator is providing therapy or medical treatment and accomplishes penetration either through the use of the relationship to coerce the victim to submit or in a manner not professionally recognized.
- **Mentally defective victim** – Where the victim is mentally defective to such an extent that he or she cannot appreciate the physical and social consequences of sexual penetration and the perpetrator knows the victim is mentally defective.
- **Concealment or surprise** - Penetration accomplished through concealment or surprise.
- **Age 13-15 and related or in the same household** - Where the victim is 13 years of age or older and under 16 and related to the perpetrator or a member of the same household.
- **Age 13-17 and in a position of authority** - Where the victim is 13 years of age or older but under 18 years of age and the perpetrator uses a position of authority to coerce the victim to submit to penetration.
- **Victim under 13** - Penetration accomplished with any person under the age of 13.

- **Consent not freely given** - Penetration accomplished after the victim has indicated by speech or conduct that consent is not freely given.
- **Correction Officer or Probation/Parole Officer** - Penetration accomplished where the victim is incarcerated and the perpetrator is a corrections officer, or where the victim is a probationer/parolee and the perpetrator is supervising the victim.

2. Fondling the genitals of a child under age 13 – A second form of AFSA involves the touching of the genitals, whether over or under the clothing, of a person under thirteen years of age. In proving this variety of AFSA, it must be shown that the perpetrator acted with the purpose of sexual arousal or gratification.

3. Pattern of sexual assault - Many children are the victims of multiple acts of sexual abuse by the same perpetrator, such as when the perpetrator lives in the victim's home and has frequent access to the victim. In such cases, a "pattern" of sexual assault may be charged even when the victim may not be able to recall details of each individual act of sexual abuse. This charge requires proof that the victim is under 16 and that more than one act of felony-level sexual abuse has occurred within a specified time period.

FELONIOUS SEXUAL ASSAULT (FSA)

Felonious sexual assault has four varieties. This crime carries a maximum penalty of 3 ½ to 7 years in state prison:

1. Sexual penetration with a person age 13, 14, or 15 – This is what is commonly referred to as "statutory rape."

2. Sexual contact with a person under age 13 – This form of FSA requires proof that the perpetrator touched the victim's sexual or intimate parts, or the victim touched the perpetrator's sexual or intimate parts, including breasts and buttocks, for the purpose of sexual arousal or gratification.

3. Sexual contact by Corrections Officer or Probation/Parole Officer – This form of FSA requires proof of sexual contact under circumstances in which the victim is incarcerated or on probation and the perpetrator uses the corrections officer of probation officer role to coerce the victim to submit to the contact.

4. Sexual contact under an aggravating circumstance causing serious personal injury – This variety of FSA requires proof that sexual contact was accomplished through any of the aggravating circumstances listed above and resulted in serious physical or psychological harm to the victim.

SEXUAL ASSAULT

This is a misdemeanor carrying a maximum penalty of 12 months in jail. It has three varieties:
1. Sexual contact with a person 13 years of age or older, under one of the above aggravating circumstances.

2. Penetration as defined above with a person 13, 14, or 15, where there is an age difference between the perpetrator and the victim of 3 years or less.

3. Sexual contact or penetration by a Probation Officer or Corrections Officer with an inmate or probationer/parolee. This crime differs from the felony level varieties in that it need not be shown here that the perpetrator used the position of authority to coerce the victim to submit to the sexual activity.

OTHER STATUTES

Other statutes regulating sexual activity in New Hampshire include laws against incest under RSA 639:2 (having sex or living with a person closely related by blood) and endangering the welfare of a child by soliciting penetration or by having a child pose for child pornography (RSA 639:3).

OTHER IMPORTANT LEGAL PRINCIPLES

Victim's Testimony: If a case goes to trial, the victim will almost certainly have to testify.

Rape Shield Privilege: Consensual sexual activity with someone other than the perpetrator is generally inadmissible. It is not admissible to show promiscuous character. It may be admissible to show the source of semen or injury. Sexual activity with the perpetrator is generally admissible with adult victims to demonstrate consent.

Clothing: Manner of dress is inadmissible to imply consent.

Spousal Privilege: Inapplicable to sexual assault cases.

***Corroboration*:** The victim's testimony is not legally required to be corroborated. This means that the testimony of a victim is sufficient to prove any sexual assault, even where there is no independent proof. Nonetheless, corroboration is crucial in every case.

EMOTIONAL NEEDS OF THE PATIENT

CRISIS CENTER ADVOCACY

In all instances the hospital or provider shall immediately call an advocate from the local crisis center to come to the hospital and meet with the patient. The advocate should be introduced to the patient, and the patient should be allowed to choose whether or not to speak with the advocate. Having the advocate already present at the hospital will allow the patient to more readily access the support offered by the local crisis center, if he/she chooses. Confidential patient record information should not be shared with the crisis center advocate unless it is done so by the patient, thus avoiding any medical records confidentiality issues.

Crisis center advocates are specially trained to provide patients with free, confidential, non-judgmental, emotional support, information, and resources so that they can make informed decisions about their care following a sexual assault. The role of the advocate at the hospital is to support the patient during the medical exam and to help the patient understand the process and options that are available to them. Sexual assault is a traumatic experience that can be difficult to process, and patients may experience a wide range of emotions. The crisis center advocate, whose communication with the victim is privileged under RSA 173-C:2, can help address these emotional needs while maintaining the patient's confidentiality. Patients who have experienced sexual assault are usually better able to respond to procedures when they are supported, believed and safe.

It is important that the Emergency Department staff be familiar with their local crisis center(s) and the services that they offer the medical facility. (See Appendix B)

WORKING WITH VICTIMS

Sexual Assault is a form of interpersonal violence that is prevalent in the United States and here in New Hampshire. Anyone can become a victim of sexual assault, and sexual violence transcends every socio-economic, cultural, gender, sexual orientation, age, physical ability, mental development and religious classification. Sexual offenses can be different kinds of crimes, including sexual assault, incest, sexual harassment, indecent exposure, child molestation, marital sexual assault and voyeurism. In each of these cases, the assailant uses sex to exert control and power over the victim. The offender may be a stranger to the victim, but most often the offender is someone the victim knows and trusts. Indeed, the offender may be an acquaintance, partner, husband, parent or other family member. A pre-existing relationship between the victim and offender does not make the crime any less serious or traumatic, and may in fact present additional challenges for the victim.

As with all forms of trauma, each individual has her/his own way of coping with the effects of the trauma. Sexual assault is certainly no different, and in the aftermath of an assault a victim may present exhibiting a wide range of emotions. Some victims may appear calm, indifferent, submissive, angry, uncooperative or even hostile to those trying to help them. They may also laugh or giggle at seemingly inappropriate times. Because everyone reacts differently following a sexual assault, victims should be allowed to express their emotions in a non-judgmental and supportive environment. It is critical that medical staff understand that there is no 'right' or

'wrong' way for a victim to respond following an assault, and a victim's emotional reaction should in no way influence the quality of care a patient receives. How a victim presents emotionally at the hospital is in no way indicative of the degree of seriousness of the assault, nor should be taken as evidence that an assault did or did not occur.

While reactions to a sexual assault may vary significantly for each individual, there are certain common feelings and fears that many victims face including:

- Fear of not being believed
- Fear of being blamed for the assault
- Fear that the offender may come back, and/or retaliate
- Fear of unknown medical and/or criminal justice processes
- Fear of friends and family finding out
- Fear of being labeled a 'victim'
- Feelings of shame and/or embarrassment
- Feelings of guilt
- Feeling suspicious and/or hypervigilent
- Feeling unsafe or scared
- Feeling a loss of control

It is the duty and obligation of the responding personnel to do their best to address these concerns in a way that is appropriate and respectful to the needs of the victim.

RESPONDING TO VICTIMS

Members of the hospital and/or medical staff may be the first contact that a victim has after being sexually assaulted. As such, it is crucial that the response the victim receives be non-judgmental, supportive and informed to ensure that they do not experience further trauma. An appropriate response by the hospital and/or medical staff can significantly impact in a positive way the long-term recovery of victims. Below are some suggestions for responding appropriately to the needs of sexual assault victims in a hospital setting.

- Be aware that some victims may have had previous negative experiences with medical personnel, and may be wary of how they will be treated now. If the victim is previously known to the medical facility or provider for other reasons unrelated to the sexual assault, it is important that the victim be treated in a fair and impartial way, regardless of any previous contact.

- In order to prevent making incorrect assumptions, nothing about the victim's life or the nature of the assault should ever be assumed. This is especially true for assuming the sexual orientation of either the victim or the offender. There are many documented instances of same-sex sexual assault, and these assaults should be addressed in the same manner as all other forms of sexual assault. Also, the gender of the offender should never be assumed, since both men and women are capable of perpetrating sexual assaults.

- Experiencing a sexual assault is in many ways the ultimate loss of control for victims. For this, and other reasons, it is imperative that the patient be informed about the medical

process, and every effort should be made to give a sense of control back to the patient. Care should be taken to explain each step of the medical process, and the patient should be allowed to ask questions and make decisions about the care they are receiving. It is important that the medical personnel respect any choices made by the victim.

- It is important to note that offenders can often be family members or caretaker/service providers, especially in child abuse and elderly/incapacitated adult abuse cases. There may also be times where the offender presents as the "secondary victim" or "helping friend". Professionals need to be aware of this so the patient does not experience re-victimization, or have their decisions unduly influenced by the unwanted presence of this individual. Always ask the victim (without anyone else present) who they would like to have in the exam room and be sure to respect their decision.

- Every effort should be made by the medical personnel to assist and facilitate communication with the victim. Victims may have difficulty communicating for a number of reasons including: shock from having experienced trauma, having been drugged, not speaking English, being hearing impaired, having a cognitive defect or impaired or reduced mental capacity that makes it difficult to comprehend questions, or they may not possess the language and communication skills necessary to explain what has happened to them. Medical personnel should make every possible effort to clearly and effectively communicate at a level that is appropriate and commensurate with the victim's ability.

- When treating the **hearing impaired patient**, Section 504 of the Federal Rehabilitation Act of 1973 establishes that any agency (including hospitals and police departments) that directly receive federal assistance or indirectly benefit from such assistance, must be prepared to offer a full variety of communication options in order to ensure that hearing impaired persons are provided with effective health care services. These options, which must be provided at no cost to the patient, include an arrangement to provide interpreters who can accurately and fluently communicate information in sign language. Examiners may contact the ***Interpreter Referral System***, seven days a week, 24 hours a day at **(800) 552-3202** for emergencies only.

- Feelings of guilt and shame, and that the victim somehow 'caused' the assault are common experiences. These feelings can be especially strong in cases where alcohol was involved, or when a male is the victim of the assault. Victims may feel ashamed that they were unable to protect themselves from the assault, and/or confused if they experienced an involuntary physiological response to the assault. It is important that the victims be reassured that the assault was not their fault and whatever they did to survive the assault was the right thing to do.

- It is important to recognize that sexual assault affects everyone involved with the primary victim of the crime. The family and friends of the sexual assault victim are also, in many ways, victims of the sexual assault and may experience feelings similar to those of the actual victim. It is important to recognize that this population may need assistance as well, and to help them access the resources available at the local crisis center. These so-called 'secondary victims' are usually able to better support and respond to the needs of the primary victim when they themselves are receiving support and services.

- Certain victims may be hesitant to present for medical attention out of fear that they will get in trouble because of their conduct before or after the assault. This can be a particular concern for the adolescent population where underage drinking, drug consumption and sneaking out or lying to their parents or caregivers may have occurred. It is important to reassure victims that any decision or choice they made does not mean they deserved to be sexually assaulted

PRESENTATION OF PATIENT

EMERGENCY MEDICAL SYSTEM (EMS) RESPONSE

- A life-threatening emergency should be treated as dictated by area EMS protocols.
- Because of the health implications associated with sexual assault, the patient should always be encouraged to seek medical care as soon as possible.
- If the patient is 18 or older, and a sexual assault has occurred, the patient should be asked if she/he would like the police contacted.
- If the patient is under 18, and a sexual assault has occurred, the police should be contacted immediately.
- The patient should be advised not to eat, drink, shower, douche, go to the bathroom or change clothing if at all possible.
- If pre-hospital personnel are called and there is no life-threatening situation and the crime is being reported, they should wait for police to secure the scene, as this is a crime scene.
- If a cellular phone or HEAR system is used, the word "assault" not "sexual assault" should be used in reporting with further details given at the hospital. In order to protect the privacy of the patient, whenever possible, a landline should be used to report to the hospital.
- If the patient has removed clothes worn during the assault, they should be put in separate **paper** bags and be brought to the hospital with the patient.
- If for any reason, regardless of gender, EMS personnel need to touch the patient, verbally request permission to do so from the patient, explaining what needs to be done and why.
- Limit the amount of physical contact with the patient to avoid unnecessary transfer of physical evidence.
- When transferring patient to a local hospital for treatment, call dispatch and request that crisis center personnel be dispatched to the hospital as well.
- If the patient refuses treatment and/or transport to the hospital, document all findings and observations, and complete the necessary paperwork.

LAW ENFORCEMENT ACCOMPANIMENT

- Depending on your area, law enforcement investigators may be present, or not, during the examiner's history taking. The final decision in regards to who is present during history taking is one made by the patient.
- **There is no time when it would be appropriate for the law enforcement officer to be present during the physical examination and evidence collection.**
- The role of law enforcement in sexual assault investigations is thoroughly discussed in the Attorney General's *Sexual Assault: A Protocol for Law Enforcement Response and Investigation of Adult Sexual Assault Cases.*
- When a patient has reported the assault to law enforcement, it is appropriate and expected that the examiner share pertinent information with that law enforcement official regarding the sexual assault.

EMERGENCY DEPARTMENT RESPONSE

- Whether the sexually assaulted patient arrives by ambulance, alone or with law enforcement, the sexual assault should be treated as a medical emergency.
- The patient should be escorted as soon as possible to a private location within the hospital where an examination and treatment can take place.
- **The hospital shall immediately call a sexual assault crisis advocate from the local crisis center and have that person available to meet with the patient.**
- The examiner should explain to the patient that crisis center advocates provide free, confidential crisis intervention and on-going counseling and emotional support, both to the patient and the patient's family. The advocate can also explain legal procedures and provide necessary referrals such as support groups and therapists.
- The patient should be introduced to the crisis center advocate and given the option of meeting privately. If the patient declines, the examiner should give the patient contact information about the local crisis center. Whenever possible, the crisis center advocate should wait until the examination is complete to ensure the patient has not changed her mind.
- In hospitals that provide Sexual Assault Nurse Examiner (SANE) services, the SANE should be notified as soon as the patient presents at the emergency room.
- Regardless of who will complete the medical/forensic evaluation, all the available options should be reviewed with the patient. The patient's decision whenever possible should be carried out by the health care providers.

OUT-OF-STATE SEXUAL ASSAULT

Because the state of New Hampshire borders Canada, Vermont, Maine and Massachusetts, it is not only conceivable but also probable that a victim of sexual assault, who experienced the assault in another state or country, will come to a New Hampshire hospital for an examination.

In the event the sexual assault occurred outside the state of New Hampshire, the examiner should adhere to the following recommendations:

- Utilize the *Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation, Fourth Edition 2005* and the accompanying evidence collection kit.

In all cases of reported sexual assault, the law enforcement agency in the jurisdiction where the assault occurred is the law enforcement agency charged with investigating the assault and facilitating transfer of the evidence collected from the hospital to the appropriate forensic laboratory.

SPECIAL PROGRAMS

THE NEW HAMPSHIRE SEXUAL ASSAULT NURSE EXAMINER (SANE) PROGRAM

New Hampshire's goal is to provide statewide consistent care that respects the emotional and physical needs of the sexually assaulted patient while collecting the best possible medical/forensic evidence. The state recognizes the many emergency room doctors and nurses who currently provide excellent care to victims of sexual assault, but in an effort to ensure that this care is uniform and standardized throughout the state, the Sexual Assault Nurse Examiner (SANE) Program was created.

A SANE is a Registered Nurse (RN) who has been specially trained to provide comprehensive care to patients who have experienced sexual assault. The RN has demonstrated competency in conducting a medical/forensic examination as well as the ability to testify in court when necessary. There is differentiation made between the SANE-A, who evaluates the adolescent and adult population, and the SANE-P who is additionally trained in the evaluation of the pre-pubertal child.

The goal is to have all sexual assault medical/forensic examinations in New Hampshire performed by Sexual Assault Nurse Examiners or physicians and other advanced practice professionals who have gone through the SANE training or its equivalent. For more information call the SANE Director at (603*) 224-8893,* extension 307.

NEW HAMPSHIRE VICTIMS' ASSISTANCE COMMISSION

Patients who are victims of sexual assault may also be eligible to apply to the **New Hampshire Victims' Assistance Commission** for compensation of medical/dental expenses, mental health therapy expenses, lost wages or other out-of-pocket expenses not covered by insurance or other resources available to the victim. The compensation must be directly related to the victims' condition as a result of the crime. Property losses and pain and suffering cannot be compensated using this method of compensation. In order to qualify, the victim must report the crime to law enforcement. The victim should be told to call ***1-800-300-4500*** for information about the compensation program.

In addition victims of sexual assault may be eligible for immediate funding for post assault medications. Payment for these medications can be arranged through the local crisis center.

PATIENT OPTIONS

PRE-PUBESCENT CHILDREN

In these types of cases, it is critical that there is a consistent approach to diagnosis, evaluation, and medical/forensic treatment. To this end, the New Hampshire Attorney General's Task Force on Child Abuse and Neglect developed a comprehensive document entitled *Child Abuse and Neglect: A Manual for the Pediatric Health Care Professional, Second Edition* in 1999). This protocol has been disseminated to all hospital emergency rooms across the state, and includes sample documentation forms and guidelines that should be followed when treating pre-pubescent children. While many children do not come forward immediately following the sexual abuse, children who DO present in an acute manner will require thorough evidence collection procedures. In those instances, the State of New Hampshire Sexual Assault Evidence Collection Kit should be modified to accommodate the examination of the child. The highlights of these modifications can be found on the instruction sheet and in Step 2.

When examining a child, the local crisis center should be contacted to support the non-offending parents/family members during the exam.

In addition, the State of New Hampshire is currently collaborating with county teams to establish a Child Advocacy Center (CAC) in each county, based a model established in Rockingham County in 2000. The purpose of these centers is to provide a comprehensive, culturally competent, multidisciplinary team response to child abuse and neglect cases, in a dedicated child-friendly setting. The team response includes representatives from law enforcement, DCYF, prosecution, mental health, medical, and victim/witness and crisis center advocates. The goals of a CAC included reducing the trauma to child victims by decreasing the number of interviews, promoting collaboration among disciplines and enhancing the overall investigations and prosecutions of child abuse and neglect cases.

ADOLESCENTS

The sexual assault of an adolescent, and the decision whether to perform the sexual assault kit can be difficult. For female patients who have reached the onset of their menses, this protocol should be followed. For male patients who have reached Tanner Developmental Stage III, this protocol should be followed. All other populations of children require the practitioner to follow the previously mentioned C*hild Abuse and Neglect: A Manual for the Pediatric Health Care Professional* and the evidence kit with modifications as described in this protocol.

REPORTING TO LAW ENFORCEMENT

Recognizing that a successful prosecution of a sexual assault case is dependent upon a cooperative victim**, most sexual assault cases of patients over the age of 18, are not required to be reported to the police, and it is the victim's decision whether or not to report the crime.** The current laws under RSA 631:6 are as follows:

Child maltreatment is unfortunately not uncommon and any examiner who deals with children will be faced with situations involving abuse and/or neglect. New Hampshire law (RSA 169-C) requires that any person who has reason to suspect that a **child under the age of 18 has been abused or neglected must report the case to the Central Intake Office of the Division of Children Youth and Families at 1-800-894-5533 or 603-271-6556**. Even if there is no current injury, suspected child abuse must be reported under RSA 169-C. There are no exceptions. (See Appendix F)

If the victim is 18 years of age or older, and has received a gunshot wound or other serious bodily injury, the injuries must be reported to the police. As defined in RSA 161-F:43 "*serious bodily injury" means any harm to the body, which causes or could cause severe, permanent or protracted loss of or impairment to the health or of the function of any part of the body.* Exception as defined in RSA 631:6: A person who has rendered treatment or other assistance is excepted from the reporting provisions if the person seeking or receiving treatment or other assistance: (a) is 18 years of age or older, (b) has been a victim of a sexual assault offense or abuse as defined in RSA 173-B:1, and (c) objects to the release of any information to law enforcement officials. The exception shall not apply if the sexual assault or abuse victim is also being treated for a gunshot would or other serious bodily injury.

Elderly and mentally incapacitated adults are at extremely high risk for experiencing a sexual assault. Protective Services to Adults (RSA 161-F), provides protection for incapacitated adults who are abused, neglected or exploited. This statute applies to **any person who is 18 years of age or older and *"who is thought to manifest a degree of incapacity by reason of limited mental or physical function which may result in harm or hazard to himself or others or who is a person unable to manage his estate."*** Any person who has reason to believe that any incapacitated adult falling under this statute has been subjected to physical abuse, neglect or exploitation **must report the abuse** to their local *District Office of the New Hampshire Division of Elderly and Adult Services.* (See Appendix G) For more information, call (during business hours) **The Division of Elderly and Adult Services at 1-800-322-9191 or 603-271- 3610.**

REPORTING ANONYMOUSLY

Some patients who present themselves to the emergency department for medical/forensic treatment may, because of the trauma they have experienced, be undecided over whether to report the crime to law enforcement.

Recognizing the dual importance of being sensitive to the needs of the patient and the timely collection and preservation of irretrievable physical evidence, the anonymous reporting procedure was developed with respect to both of these considerations. The anonymous reporting procedure ensures that victims of sexual assault, who are undecided over whether or not to report the assault, have sixty days to report the assault. Patients may maintain their anonymity with law enforcement until such time as they decide to report the crime.

The evidence is collected in accordance with the New Hampshire *Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation (Fourth Edition, 2005)*, except that the identity of the patient is not documented on any of the specimens or paperwork provided in the *Sexual Assault Evidence Collection Kit.* A serial number is provided on the end of the Evidence

Collection Kit box and this serial number is used in place of the victim's name on all specimens and paperwork.

Once the examination is complete, and the patient is discharged, the examiner will turn over the anonymous kit (the same procedure as for other kits) to the law enforcement agency in the jurisdiction where the crime occurred. **Law Enforcement will then transport the evidence to the New Hampshire State Police Forensic Laboratory, just as they would in a reported case. All kits should be transported to the laboratory and SHOULD NOT be kept at the police department.**

The anonymous kit is kept in storage for sixty days from the date of the medical/forensic examination. If the victim has not reported the crime to law enforcement during this time period, the evidence will be returned to the submitting police department for final disposition. **The patient is informed that if s/he ultimately chooses not to report the crime the evidence, including clothing, will not be returned but will be sent back to the police department for disposal.**

If the patient ultimately **chooses to report** the crime to law enforcement, s/he will have received upon hospital discharge the kit serial number from the medical record. The patient will then provide that number to the police so that the evidence (in storage at the State Police Laboratory) may then be associated with the reporting victim and an investigation of the crime, including the examination of the evidence, may commence.

The Anonymous Kit cannot be completed on anyone under the age of 18. No analysis shall be performed until a report is made to law enforcement.

NOT REPORTING

Persons who are 18 years of age or older and have not sustained a gunshot wound or serious bodily injury must be asked whether they object to having their injuries reported to the police. It is their decision whether or not to report the crime to the police. If the patient chooses not to report, it is the responsibility of the health care professional to educate the patient on the fact that the evidence will be lost.

THE MEDICAL/FORENSIC EVALUATION

LOCATION

Adolescents and adults should be treated in a hospital emergency department, or a specially designed area with rapid access to the hospital emergency department. Hospitals providing sexual assault treatment should have a 24-hour emergency room facility with staff trained in sexual assault medical/forensic examinations.

HIPAA

The new regulation is the first federal medical privacy law of its kind in United State's history. While many states have laws that protect patient privacy, the new regulation creates a federal floor for privacy protections to ensure that minimum levels of protection are in place in all states.

In the most general sense, the regulation *prohibits* use and disclosure of protected health information unless expressly permitted or required by the regulation. The regulation *requires* disclosure (1) to the individual who is the subject of the information and (2) to Health and Human Services for enforcement purposes. The new regulation does not create mandatory reporting in a state where there was no previous mandatory reporting. But, by the same token, HIPAA regulations do not preempt the health care providers' obligation to report, that which is reportable under New Hampshire law.

The new federal rules do not preempt state laws that are more protective of patient privacy. In addition, the regulation does not preempt state laws that authorize or prohibit disclosure of health information about a minor to a parent or guardian. New Hampshire statutorily grants a patient the right of access to his or her medical records, which are owned by the patient but housed in the possession of the facility or provider. (RSA 151:21)

For a summary of state privacy laws see the Georgetown University Health Privacy Project's *The State of Health Privacy: An Uneven Terrain* (Health Privacy Project (July 1999). (healthprivacy.org)

CONSENT

It is standard hospital practice to obtain a patient's written consent before conducting a medical examination or administering any treatment. However, informed consent is a continuing process that involves more than obtaining a signature on a form. Therefore, all procedures should be explained as much as possible, and as many times as necessary, so the patient can understand what the examiner is doing and why. Explanation of the examination and treatment process are solely the responsibility of the examiner.

If at any time, a patient expresses resistance or non-cooperation, the examiner should immediately discontinue that portion of the process, discuss any concerns or questions the patient may have regarding that procedure and make a determination about whether or not they can continue. The examiner may consider returning to that procedure at a later time in the examination, but only if the patient then agrees. In either event, the patient should have the right

to refuse one or more tests or to refuse to answer any question without that decision negatively impacting the remainder of the exam.

The Adolescent Patient

An adolescent brought into the emergency department must give their own consent. If the circumstances permit, parental/guardian consent to examine the patient should be obtained but it is not absolutely necessary. The patient should be told that if she/he is under the age of 18, it is mandatory for the examiner to notify the *Division for Children, Youth and Families.* (See Reporting, page 13)

The Incoherent/Unconscious Patient

Due to the increasing use of drugs to facilitate sexual assault, circumstances are certain to arise where there is a high degree of suspicion regarding sexual assault, but the patient is unable to give formal consent. In these circumstances, and because evidence collection is part of the standard of care in sexual assault, and because evidence is lost with the passing of time, it is recommended that collection of all evidence except vaginal and rectal swabs take place. The evidence may be collected using the anonymous system if the patient is at least 18, and submitted to the crime lab. When and if the patient regains consciousness they can then make an informed decision about reporting or not. Should the patient choose to report, the remaining components of the exam and evidence collection can be completed.

There may be circumstances when the provider is compelled to collect evidence from vaginal/rectal orifices in an unconscious patient. In these circumstances, a search warrant should be obtained through law enforcement prior to evidence collection.

In the case of an unconscious/incoherent patient who is under the age of 18, parental consent should be obtained for all aspects of the examination, unless there is reason to believe the parent is the perpetrator

Should the unconscious/incoherent patient fail to regain consciousness, or die as a result of the assault, a report should be made to law enforcement by examining personnel.

ACUTE VERSUS NON-ACUTE SEXUAL ASSAULT

A medical/forensic examination should be performed in all cases of sexual assault, regardless of the length of time that may have elapsed between the time of the assault and the examination. Some patients may ignore symptoms that would ordinarily indicate serious trauma, both physical and psychological. There may also be areas of tenderness which will later develop into bruises, but which are not apparent at the time of initial examination.

If the assault occurred within 5 days of the examination it should be considered acute, and an evidence collection kit should be used. If it is determined that the assault took place more than 5 days before the examination, the use of an evidence collection kit is generally not necessary. It is important that the examiner realize that evidence may still be gathered by documenting findings made during the medical/forensic history and examination, as well as taking photographs. **It is equally important that the examiner be aware that the time frame**

for specific pieces of evidence may differ from the "5 day" rule. For specific time frames the examiner should reference the specific step in the protocol.

The job of the examiner is to obtain a history, examine the patient thoroughly, describe the findings objectively, collect necessary forensic evidence and treat the patient on an individual basis. Each case should be completed with the knowledge that the examiner may be expected to give testimony as to the patient's evaluation and treatment.

When a medical/forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. The coordination of medical and forensic procedures is crucial to the successful examination of sexual assault patients. For example, in order to minimize patient trauma, blood drawn for medical purposes should be done at the same time as blood drawn for evidence collection purposes. When evidence specimens are collected from the oral, vaginal, or rectal orifices, cultures for sexually transmitted infection should be taken at the same time.

COLLECTING AND PACKAGING EVIDENCE

- The examiner should always wear powder-free gloves when collecting and packaging evidence.
- The examiner should always change gloves between specimen collections.
- Clothing and other evidence specimens must be sealed in paper or cardboard containers.
- All wet evidence should be dried prior to packaging whenever possible.
- In the event that the evidence is wet, the items may be first placed in paper bags then into plastic bags, provided that holes for ventilation are made in the plastic bag.
- **Urine specimens obtained should be sealed in a biohazard bag, then in a paper bag, and never placed inside the evidence kit**.
- All hospital Occupational Health and Safety regulations should be followed per institutional policy.
- Envelopes containing evidence should never be sealed with the examiner's saliva. Self-adhesive envelopes or tape should be used.
- Paper bags should be sealed with tape, never staples.

CHAIN OF CUSTODY

While medical information and forensic evidence may be collected together, forensic evidence must be collected, preserved and documented in a manner that ensures its admissibility at a later date as evidence in court. The custody of the evidence in the collection kit, as well as any clothing or other collected items, must be accounted for from the time it is initially collected until it is admitted into evidence at trial. This is accomplished by establishing a **"chain of custody"**. Chain of custody chronologically documents each individual who handles a piece of evidence from the time it is collected. The unbroken chain of custody establishes the integrity of the evidence and any subsequent analysis of the evidence and is a prerequisite to admitting the evidence in court.

Sealing the kit with the evidence tape provided, and initialing that seal, ensures the integrity of the medical/forensic evidence by establishing that it has not been tampered with. This also applies to any clothing or other items collected that are not sealed in the kit.

The chain of custody of a piece of evidence is established by documenting the name and date that the item is received and/or transferred to another individual, beginning at the date and time the evidence is initially collected. The evidence must also be labeled with the name of the patient or kit serial number, the sexual assault examiner and the source of the specimen. Additionally, the evidence must be kept in a manner that precludes tampering. This is accomplished by sealing the evidence kit with the evidence tape provided, initialing the seal and by keeping the evidence in a secure place. It is important to emphasize that the documentation of the chain of custody includes the receipt, storage, and transfer of evidence.

STEP 1 - AUTHORIZATION FOR COLLECTION AND RELEASE/TRANSFER OF EVIDENCE AND PROTECTED HEALTH INFORMATION

Fill out all requested information and have patient (or parent/guardian when applicable) and witness sign where indicated. This form should be completed in all instances, regardless of patient age. The bottom of the form indicates where each duplicate copy should go.

STEP 2 - SEXUAL ASSAULT EVIDENCE COLLECTION KIT INVENTORY

Fill out all requested information, date and sign. This form should be completed in all instances, and will give the examiner an account of what was and was not collected at the time of the exam should the information be necessary during testimony. The bottom of the form indicates where each duplicate copy should go.

STEP 3 - SEXUAL ASSAULT MEDICAL/FORENSIC REPORT FORM

Fill out all requested information utilizing the forms provided. This form should be completed in all instances, regardless of patient age. Do not copy and submit the rest of the patient's medical record in the evidence kit. The bottom of the form indicates where each duplicate copy should go.

Date and Time of Assault/Date and Time of Collection

It is essential to know the period of time that has elapsed between the time of the assault and the collection of evidence. The presence or absence of semen may correspond with the interval since the assault.

Gender and Number of Offenders

Forensic serologists seek evidence of cross-transfer of trace materials among the patient, offender(s), and scene of the crime. These trace materials include foreign hairs and the deposit of secretions from the assailant(s) on the patient. The gender of the offender may determine the type of foreign secretions that may be found on the patient's body and clothing. Therefore, the

serologist should be informed whether to search for foreign semen or vaginal secretions, so they can focus the analysis on the relevant stains.

Details of the Assault

An accurate but brief description of the assault is crucial to the collection, detection, and analysis of physical evidence. This includes the discovery of attempted oral, anal, rectal, and vaginal penetration of the victim, oral contact by the offender, ejaculation (if known by the victim) and penetration digitally or with foreign object(s).

Action of Patient Since the Assault

The quality of evidence is critically affected both physically and chemically by actions taken by the patient and by the passage of time. For example, the length of time that elapses between the assault and the collection of evidence, as well as self-cleansing efforts of the patient, can affect the rate of drainage of semen from the vagina or rectum. The presence of evidence such as foreign hairs, fibers, plant material or other microscopic debris deposited on the patient by the assailant or transferred to the patient at the crime scene may also be affected. It is important for the analyst to know what, if any, activities were performed prior to the examination, any of which could help explain the absence of secretions or other foreign material. Failure to explain the circumstances under which semen or other body fluids could have been destroyed might jeopardize criminal prosecution if apparent contradictions cannot be accounted for in court.

Lubricants/Contraceptive Methods/Menstruation Information

Lubricants of any kind, including oil or grease, lotions or spermicide, are trace evidence and may be compared with potential sources left at the crime scene or recovered from the body of the assailant. Knowing whether or not a condom was used also may be helpful in explaining the absence of semen.

Tampons and sanitary napkins can absorb all of the assailant's semen, as well as any menstrual blood present. Additionally, the presence of blood on the vaginal swab could either be from trauma or as a result of menstruation.

Last Consensual Sex

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers that are inconsistent with a mixture from only the patient and the assailant. A mixture of semen from a assailant and the patient's pre-assault or post-assault sexual partner could lead to DNA evidence which, if unexplained, could conflict with the patient's own account of the assault.

Many forensic analysts request that the examiner ask patients if they engaged in voluntary sexual intercourse within several days prior to or after the assault. If so, patients are then asked the date of the contact in order to help determine the possible significance of semen remaining from such activity.

Very often, the date of last voluntary coitus is asked during the physical examination. Knowing who the prior sexual contact was is significant only to the extent that saliva and blood samples from the individual involved can be made available for comparison if needed. **Therefore, this person's identity is not relevant either to the medical examination or for the initial findings of the crime laboratory and should not be sought at time of initial examination.**

Many factors can influence the interpretation of the scientific findings. Semen can remain in the vagina and cervix from several hours to several days, and for shorter periods of time in the rectum. Although the majority of sexual assault cases involve detectable semen lasting up to 72 hours, the disappearance of semen from the vaginal or rectal orifice usually is gradual, not sudden. The amount of residual semen can be extremely variable, depending on the patient's own physiology, any cleansing activities following coitus, the original volume of semen, the effectiveness of the medical collection procedure, and the sensitivity of the analytical method employed by the crime laboratory. If the patient has had recent voluntary coitus, then the ejaculate of that sexual partner could be present on the specimen and not necessarily be that of the assailant. In order to interpret the results correctly (to avoid falsely excluding the assailant as the donor of the semen or falsely including an innocent party), correct interpretation of analytical results requires knowing all those persons who could have contributed to the sample.

The recollections of the patient may become less accurate if they go unsolicited until after the crime laboratory identifies discrepancies between the assailant's known DNA type and the DNA type of the seminal stains. In some jurisdictions, several months may elapse between the initial medical examination, the crime laboratory analysis, and the follow-up interview with the prosecutor and victim.

STEP 4 - LIQUID BLOOD SAMPLE

In some instances of sexual assault, dried deposits of blood, semen, or saliva may be found at the crime scene or on the body or clothing of either the patient or suspect. The purpose of collecting whole blood is to determine the patient's DNA profile for comparison with such deposits. For this reason, one lavender top (EDTA) tube, equaling 5-7 milliliters of blood should be used for evidence collection purposes. If blood is also needed for medical purposes it should be obtained at this time, and retained at the hospital. Return filled and labeled blood tubes to bubble pack bag and place in Known Blood Sample envelope (Step 4). Seal and fill out all information requested on the envelope. **All blood tubes should be taken from the hospital supply**

Suspected Drug Facilitated Sexual Assault

Unknown drug ingestion has become a common tool of sex offenders to aid in the commission of their crimes. Commonly used drugs include Ketamine, Rohypnol, Gamma Hydroxybutyrate (GHB), Ecstasy and a variety of prescription medications. These drugs are often mixed with alcohol or other beverages to incapacitate the victim. Once the victim recovers from the effects of the drug, anterograde amnesia may make it difficult to recall the events following the ingestion of the drug. For this reason, sexual assault victims may not be aware of the assault or whether or how they were drugged.

The examiner should be aware of the possibility of unknown drug ingestion and discuss the possibility with the patient. Ask the patient to describe any symptoms that may indicate the use of a drug and offer to test for the drug's presence in the body. It is important for the examiner to realize that their hospital-based laboratory may be limited in its ability to test for specific substances. Appendix E provides some web-based resources the examiner may find helpful.

On October 12, 1996, a federal law entitled "The Drug-Induced Rape Prevention and Punishment Act of 1996" was enacted. The bill provides penalties of up to 20 years imprisonment for persons who intend to commit a crime of violence by distributing a controlled substance to another individual without that individual's knowledge.

Testing for the Presence of Drugs Used to Facilitate Sexual Assault

If the patient presents with drowsiness, memory loss, impaired motor skills, etc. or there is a suspicion of unknown drug ingestion, the patient should be asked for consent to have a blood and/or urine sample collected for identification of drugs commonly used to facilitate sexual assault.

If the patient consents to the testing, the following procedures should be followed:

1. If ingestion was within **48 hours**, collect both blood and urine samples.

2. If ingestion was between **48 and 96 hours**, collect a urine sample only.

3. If ingestion was over **96 hours**, neither sample should be collected.

Blood Sample

Collect a 10 milliliter sample into a Purple Top (EDTA) tube **from the hospital supply**, using sterile procedures. Label tube with: Patient's name, DOB, date, time and phlebotomist's initials. Place blood tube in blood sample collection envelope. (STEP 4).

Urine Sample

Collect a minimum of 100 milliliters urine into a sterile urine collection container from the hospital supply. Label with patient's name, DOB, date, time and collector's initials. Place urine container in a liquid tight re-sealable plastic bio-hazard bag, then place that plastic bag into a paper evidence bag, seal, label and send with kit to the crime lab. Refrigerate urine sample to prevent sample degradation. If transport of specimen to the crime lab is to exceed one hour, freeze the urine specimen. **DO NOT place urine sample in the Sexual Assault Evidence Collection Kit.** No toxicology testing will be performed on samples collected anonymously until such incidents are reported.

STEP 5 - OUTER CLOTHING

STEP 6 - UNDERPANTS COLLECTION

Clothing frequently contains the most important evidence in a case of sexual assault. The reasons for this are two-fold:

- Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs, and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the patient, the same substances often can be found intact on clothing for a considerable length of time following the assault.
- Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the patient with trace evidence collected from the suspect and/or the crime scene.

The most common items of clothing collected from patients and submitted to crime laboratories for analysis are underwear, hosiery, blouses, shirts, and slacks. There are also instances when coats and even shoes must be collected. **These items should only be taken if the patient wore them at the time of the assault and they likely contain evidence in the case. A patient's wallet, cash and credit cards should not be taken. A patient's jewelry should not be taken. If the examiner believes material has been transferred from the assailant onto the victim's jewelry, the jewelry should be swabbed using sterile water and swabs, and packaged appropriately as part of the evidence collection kit.**

In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. **Therefore, each garment should be placed separately in its own paper bag to prevent cross-contamination.**

When the determination has been made that the victim's clothing contains possible evidence related to the assault, **with patient consent**, those items should be collected. The patient has the right to refuse to turn over any article of clothing. Underpants of female victims of sexual assault where penile-vaginal penetration has occurred should always be collected if the patient is seen within 72 hours of the examination, even if the patient has changed underpants since the assault.

If it is determined that the patient is not wearing the same clothing, the examiner should inquire as to the location of the original clothing. This information should be given to the investigating officer so that he or she can make arrangements to retrieve the clothing before any potential evidence is destroyed.

The patient may be wearing a sanitary napkin at the time of the exam. In this instance the underpants need not be collected. Instead, the napkin should be collected as evidence by drying and folding the napkin in on itself, inserting the napkin into the underpants collection bag, and labeling and sealing the bag accordingly.

CLOTHING COLLECTION PROCEDURE

The clothing should then be collected and packaged in accordance with the following procedures:

After air-drying items, such as underpants, hosiery, slips, or bras, they should be put into individual small paper bags. Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded

inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.

If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag with the top of the plastic bag left open. In these instances, a label should be affixed to the outside of the plastic bag, which will alert the crime laboratory that wet evidence is present inside the plastic bag. This will enable the laboratory to remove the clothing and avoid loss of evidence due to putrefaction.

It is important to remember that sanitary napkins, tampons, and infant diapers may also be valuable as evidence because they may contain semen or pubic hairs from the perpetrator. Items such as slacks, dresses, blouses, or shirts should be put into larger paper bags.

STEP 7 - ORAL SWABS AND SMEAR

In cases where the patient was forced to perform oral sex, the oral swabs and smear can be as important as the vaginal or rectal samples. The purpose of this procedure is to recover seminal fluid from recesses in the oral cavity where traces of semen could survive.

If the sexual activity occurred within 72 hours of the patient's presentation, swab the oral cavity using the two swabs provided, either individually or together. Attention should be paid to those areas of the mouth, such as between the upper and lower lip and gum, where semen might remain for the longest amount of time. Prepare the oral smear by wiping both swabs across the surface of the labeled glass slide. ***The smear should not be fixed or stained.*** Allow oral swabs and smear to air dry. Return smear to slide holder and place the swabs in the swab box. Return slide holder and swab box to the Oral Swabs and Smear envelope (Step 7). Seal and fill out all information requested on envelope.

SWAB AND SMEAR COLLECTION PROCEDURE

The purpose of making smears is to provide the forensic analyst with a nondestructive method of identifying semen. This is accomplished through the identification of the presence of spermatozoa. If no spermatozoa are present, the analyst will then proceed to use the swabs to identify the seminal plasma components to confirm the presence of semen.

If patients must use bathroom facilities prior to the collection of these specimens, they should be cautioned that semen or other evidence may be present in their pubic, genital and anal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.

The number of tests that lab personnel can perform is limited by the quantity of semen or other fluids collected; therefore, two swabs should be used when collecting specimens from the oral, anal and rectal cavities. All four swabs should be used either individually or in pairs when collecting specimens from the vaginal cavity.

When taking swabs, the examiner should take special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

Depending upon the type of sexual assault, semen may be detected in the mouth, vagina, anus or rectum. However, embarrassment, trauma, or a lack of understanding of the nature of the assault may cause a patient to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there may also be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the patient be encouraged to allow examination and collection of specimens from both the vagina and anus.

In cases where a victim is certain that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), it is important for the victim to be able to refuse these additional tests. This "right of refusal" also will serve to reinforce a primary therapeutic principle - that of returning control to the victim.

Each of the oral, vaginal/penile and anal collection envelopes contain the applicable slide with which to create the smear. When swabs are collected from each of these orifices, the first two swabs collected should be utilized to make the appropriate smear by placing the cotton end of the collected swab in the center of the slide and smearing the center of that slide with the collected specimen. Care should be taken to be sure the correct side of the slide is used to make the smear. The correct side of the slide is indicated by the label marked “oral” or “vaginal/penile” or “rectal.” ***The smear should not be fixed or stained***

STEP 8 - FOREIGN MATERIAL COLLECTION

Semen is the most common secretion deposited on the patient by the assailant. There are also other secretions, such as saliva, which can be analyzed by laboratories to aid in the identification of the perpetrator. It is important that the examiner examine the patient's body for evidence of foreign matter.

If secretions, such as saliva, seminal fluid and dried blood, are observed on other parts of the patient's body during the examination, the material should be collected using a swab. A different swab should be used for every secretion collected from each location on the body.

Oral contact with the victim’s breast or genitalia is common. It is important to ask the patient directly if and where the assailant put his/her mouth, or where the suspect ejaculated. If the patient has not bathed or showered and contact has occurred, or the patient is uncertain, collect the specimens.

Dried secretions are collected by dampening the swab with sterile water and swabbing the indicated area. After allowing the swab to air dry, it should be returned to the swab box provided. The Foreign Material Collection (Step 8) envelope should be marked as to where on the patient’s body the sample was collected and what substance is suspected (e.g. blood, semen, saliva, etc.). In the event multiple sites require collection, the examiner should obtain additional swabs and envelopes from the hospital supply and label accordingly.

EVALUATION FOR GENITAL TRAUMA

It is important to note that the majority of sexual assault cases do not involve genital trauma. However, recognition and documentation of trauma can both corroborate the patient's statements and show the level of force used in the commission of the crime. Visual inspection is the most common and available examination technique to detect genital trauma. Careful, inspection of the ano-genital region is essential. Traumatic injury may include tears, bruising, abrasions, and abnormal redness. The areas where these types of injuries are often found include the posterior fourchette, fossa navicularis, labia minora and the hymen. Not all injuries are easily seen.

There are times when the barrier to care may involve a cultural practice that the provider is unaware of, and may complicate the overall care of the patient, such as **female genital mutilation** (FGM). In this instance it is critically important that the provider be educated in the cultural practice, origins, sexual assault care and appropriate follow-ups. (For more information go the World Health Organization website at www.who.int/en/)

A few techniques have been studied that enhance the examiner's ability to recognize genital injuries. Availability of equipment and skilled examiners limits the application of these techniques but they should be considered appropriate options:

The Foley Catheter Technique

The foley technique is utilized on female patients who have reached the onset of their menses to visualize the hymen and better detect injury. A foley (12-16F) with balloon is inserted into the vaginal vault, without lubrication, following visualization and prior to the speculum examination. The foley is inserted until the balloon tip is inside the vaginal vault. The balloon is then inflated with air using a 30-60cc syringe. The balloon on average is inflated with approximately 30-50cc of air. The foley is then gently tugged on allowing the hymenal tissue to sit on the descending balloon. Should injuries to the hymen be found, appropriate photographic techniques should be employed.

To avoid loss of evidence, the foley tip can be swabbed, and the swab dried, labeled and sent to the crime lab with the other evidence for analysis.

Toluidine Blue Dye

1% Toluidine blue dye has been employed as an objective adjunct in the evaluation of ano-genital trauma because of its sensitivity for exposed dermal nuclei. Trauma can injure the epidermis and expose the nuclei of cells. Normal intact skin contains no nuclei on its surface. Toluidine blue dye application to the posterior fourchette, fossa navicularis and external tissue with subsequent removal from unstained areas by means of a destaining reagent, such as diluted acetic acid or a 10% vinegar solution has been shown to increase the detection rate of micro abrasions and lacerations by up to 58% in sexual assault patients. Studies also indicate that it does not interfere with molecular techniques used in forensic medicine.

Some references that may be helpful to the examiner:

Lauber, A., Souma, G.(1982). Use of toluidine blue for documentation of traumatic intercourse. *Obstetrics & Gynecology, 60*, 644-647.

McCauley, J.(1986). Toluidine blue in the corroboration of rape in the adult victim. *Pediatrics, 78*, 1039-1043.

Slaughter, L., Brown, C.(1992). Colposcopy to establish physical findings in rape victims. *AM J Obstet Gynecol, 166*, 83-86.

Hocheistmer, M.(1996). Effects of toluidine blue and destaining reagents used in sexual assault examinations on the ability to obtain dna profiles from the post coital vaginal swabs. *Am Academy of Forensic Science, 316*, .

Girardin, B. et al (1997). *Color atlas of sexual assault*.

Colposcopy

Magnification of ano-genital tissues with a colposcope has been utilized for some time to identify trauma in the evaluation of sexual abuse in children. The colposcope is now being used to identify and document acute trauma in adult sexual assault victims. The magnification makes it easier to see the injured areas. Colposcopes frequently have attached cameras or video recording devices that permit documentation. A localized pattern of genital trauma is frequently seen in women reporting nonconsensual sexual intercourse.

STEP 9 - RECTAL SWABS AND SMEAR

If the sexual activity took place within 72 hours of the patient's presentation, and after fully explaining the procedure to the patient, put the patient in either supine or prone knee-chest position, and apply gentle bilateral pressure with the examiner's hands to the patient's buttocks. Allow approximately 2 minutes for rectal dilation to occur. Swab the rectal cavity using the two swabs provided, either individually or together. To minimize patient discomfort, these swabs may be moistened slightly with sterile water. Prepare the rectal smear by wiping both swabs across the top, labeled surface of the microscope slide. **The smear should not be fixed or stained.** Allow all swabs and smear to air dry. Return smear to slide holder and place both swabs in the swab box. Return slide holder and swab box to the Rectal Swabs and Smear envelope. Seal and fill out all information requested on envelope.

At this time, any additional examinations or tests involving the rectum should be conducted.

STEP 10 - PUBIC HAIR COMBING

Due to the advent of DNA analysis, pulled pubic hairs are no longer necessary under any circumstances.

PUBIC HAIR COLLECTION PROCEDURE

The pubic hair combings and the comb are placed in the Pubic Hair Combings envelope (Step 10). After the labeling information is completed, the envelope should be sealed. Combing should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed.

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected in the same manner as other dried fluids. The swab should be placed in a small paper envelope and labeled "possible secretion sample from head/pubic hair." Although this specimen may also be collected by cutting off the matted material, it is important to obtain the patient's permission before cutting any amount of hair.

STEP 11 - EXTERNAL GENITALIA SWABS

If the circumstances of the assault suggest there has been contact between the victim's genitalia and the assailant's mouth or penis, and the patient has not bathed or showered since the assault, there exists the possibility that saliva or seminal fluid may be found on the patient's external genitalia. In this instance, the two cotton tipped swabs in the envelope should be moistened slightly with sterile water and the entire pubic area should be swabbed, the swabs dried and packaged appropriately.

STEP 12 - VAGINAL/PENILE SWABS AND SMEAR

When collecting the vaginal specimens, it is important not to aspirate the vaginal orifice or to dilute the secretions in any way.

If the sexual activity occurred within <u>5 days</u> of the patient's presentation, utilizing a speculum in the patient who has reached the onset of menses, swab the vaginal vault using two of the four swabs provided, either one at a time or as a pair. Prepare the vaginal smear by wiping one pair of swabs across the top, labeled surface of the microscope slide. **The smear should not be fixed or stained.** Use the second set of swabs one at a time to gently swab the cervical os of the patient. Allow all swabs and smear to air dry. Return smear to slide holder and place each pair of swabs in their respective swab boxes, marking them appropriately "vaginal" or "cervical". Return slide holder and swab boxes to the Vaginal Swabs and Smear envelope. Seal and fill out all information requested on envelope.

In the pre-menses girl no speculum is utilized during the exam, and the set of cervical swabs is not obtained. The remaining two vaginal swabs should be moistened slightly with sterile water and used to swab the introitus.

Immediately following this procedure, the remainder of the pelvic examination should be performed and appropriate medical intervention and treatment should occur.

For the male patient, both adult and child, the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that

the penis was introduced into a vaginal orifice; and feces or lubricants might be found if rectal penetration occurred.

If the male patient has not bathed or showered, the proper method of swabbing the penis is to slightly moisten the swabs provided with sterile water, and thoroughly swab the external surfaces of the penile shaft and glans. The swabs may be used two at a time. All outer areas of the penis and scrotum where contact is suspected should be swabbed. Allow all swabs to air dry. Place both swabs in the swab box. Return swab box to the Penile Swabs envelope. Seal and fill out all information requested on envelope.

Care should be taken to avoid the urethral meatus as this could result in obtaining a DNA sample of the victim instead of the perpetrator.

Any other applicable hospital testing should be done at this time.

COLLECTION OF TAMPONS AS EVIDENCE

The sexual assault examiner may find that the patient has inserted a tampon in response to menstruation. The tampon may have absorbed residual semen from the assailant. It will therefore be necessary to collect the tampon as evidence. Obtain a sterile urine specimen collection container from hospital supply. Label the container with the name of the patient, date, time and collector's initials. Punch three or four air holes through the cover of the container. Carefully remove the tampon from the patient's vaginal cavity, or ask the patient to remove the tampon, and place it in the urine specimen container. Cover the specimen container and place it into a **paper bag**. Label the bag with the name of the patient, date, time and collector's initials. Seal the paper bag with tape and keep it separate from the Evidence Collection Kit. Do not attempt to secure the tampon and packaging in the Evidence Collection Kit box.

STEP 13 - MEDICAL/FORENSIC EXAMINATION FORM

Findings from the medical/forensic examination should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending examiner; however, there will be times when it is necessary. If testimony is needed, a thoroughly completed and legible medical record and accompanying body diagrams and/or photographs will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical/forensic examination the examiner should focus on statements made by the patient as they relate to the assault and any anticipated evidence collection and treatment that will be required, as well as observations made during the examination. Drawing unfounded conclusions should be avoided.

EVALUATION FOR SEXUALLY TRANSMITTED INFECTIONS (STIs)

According to the latest *Centers for Disease Control STD Treatment Guidelines*, Trichomoniasis, Bacterial Vaginosis, gonorrhea and chlamydial infection are the most frequently diagnosed infections affecting women who have been sexually assaulted. Because the prevalence of these infections is high among sexually active women, their presence post-assault does not necessarily signify acquisition during the assault. Chlamydial and gonococcal infection among females are of special concern because of the possibility of ascending infection. In addition, post-assault evaluation can detect the Hepatitis B Virus, which may be prevented by post-exposure administration of the Hepatitis B vaccine. It is recommended that the *CDC STD Treatment Guidelines* be adhered to whenever possible. **Immediate funding for post sexual assault medications may be arranged through the local crisis center.**

Follow-Up Examination

Despite the fact that scheduling and adhering to follow-up may be difficult in this patient population, it remains essential in order to detect new infection, document healing of injury, counsel regarding treatment for other STIs or complete requested vaccinations. For these reasons the most recent CDC recommendations regarding follow-up and post exposure prophylaxis should be adhered to whenever possible. The CDC guidelines can be found at www.cdc.gov.

Prophylaxis

Knowing that follow-up can be difficult, the CDC recommends the following prophylactic regimen as preventive therapy:

1. Post-exposure hepatitis B vaccination, without HBIG at the time of initial examination if the patient has not been previously vaccinated. Follow-up doses administered at 1-2 months and 4-6 months after the first dose.

2. An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas and bacterial vaginosis following the CDC guidelines, using the section on alternative treatments when addressing changes in the appropriate treating agent.

Risk for Acquiring HIV and Postexposure Prophylaxis

Although HIV-antibody seroconversion has been reported among persons whose only known risk factor was sexual assault or abuse, the risk for acquiring HIV infection through a single episode of sexual assault is low. The overall probability of transmission of HIV during a single act of intercourse from a person known to be HIV-infected depends on many factors.

The CDC makes the following recommendations for postexposure assessment of adolescent and adult patients **within 72 hours** of the sexual assault:

1. Review HIV/AIDS local epidemiology and assess risk for HIV infection in assailant.

2. Evaluate circumstances of assault that may affect risk for HIV transmission.

3. Consult with a specialist in HIV treatment if postexposure prophylaxis is considered.

4. If the patient appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and unknown efficacy.

5. If the patient chooses to receive antiretroviral postexposure prophylaxis, provide enough medication to last until the next return visit; re-evaluate patient 3-7 days after initial assessment and assess tolerance of medications.

6. Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months and 6 months.

Patients should be counseled regarding the availability of undergoing HIV antibody testing in either a confidential or anonymous manner. **"Confidential"** means the test is identified with the patient's name or other unique identifier, offered by the provider and are subject to the confidentiality protections under RSA 141:F-8**. "Anonymous**" means the patient is tested at a state-funded clinic where no personally identifying information is required in order to receive services and the patient is not known to any staff of the clinic. At this time, the ability to determine HIV status utilizing anonymous test records has not been determined by the court.

The patient should be given a copy of the *HIV Information Sheet and the list of Anonymous New Hampshire STI and HIV Counseling and Testing Sites*, which are included in the kit (See Appendix D) The patient should be offered HIV counseling as soon as possible by a trained counselor in order to realize that the possibility of contracting HIV is outweighed by the probability that a single exposure will not transmit the infection. All persons electing to be tested for HIV should receive pretest and posttest counseling.

STEP 14 - PATIENT INFORMATION FORM

The discussion of follow-up services for both medical/forensic and counseling purposes is an important treatment aspect for sexual assault victims. Before the patient leaves the hospital, a *Patient Information Form* should be completed. The type and dosage of any medication prescribed or administered should be recorded on the first portion of this form.

The original copy of the patient information form should be given to the patient and the second copy retained for the hospital's records.

STEP 15 - INFORMED CONSENT FOR EMERGENCY PREGNANCY PREVENTION

Levonorgestrel tablets, 0.75 mg, is a progestin-only emergency contraceptive that is now available by prescription. To obtain optimal efficacy, the first tablet should be taken as soon as possible within 72 hours of intercourse. The second tablet must be taken 12 hours later. The significant decrease in contraindications and side effects commonly associated with other pregnancy prevention medication make it the best alternative for this patient population. More information can be obtained at www.go2planb.com.

The following is information obtained from the American College of Emergency Physicians *Evaluation and Management of the Sexually Assaulted Patient.* The tables below aid in prescribing pregnancy prevention medication following a sexual assault. These guidelines should be followed in conjunction with using the "Informed Consent Form for Emergency Pregnancy Prevention Pills" that can be found inside the evidence collection kit. It is also important to note that this information should not serve as the sole source for prescribing information or clinical decision-making.

Table 1

Brand	**Pills per Dose****	**Ethinyl Estradiol per does (ug)**	**Levonorgestrel per dose (ug)**
Ovral	2 white pills	100	0.50
Alesse	5 pink pills	100	0.50
Nordette	4 light-orange pills	120	0.60
Levlen	4 light-orange pills	120	0.60
Lo/Ovral	4 white pills	120	0.60
Triphasil	4 yellow pills	120	0.50
Tri-Levlen	4 yellow pills	120	0.50
Ovrette	20 yellow pills	0	0.75

Table 2

Medication+	**Dose++**	**Repeat Dosing if Required**
Metoclopramide	10 mg	6 h
Meclizine	25 to 50 mg	24 h
Diphenhydramine	25 to 50 mg	4 to 6 h
Trimethobenzamide	200 mg suppository	6 to 8 h
Promethazine	25 mg suppository	8 to 12 h
Dramamine	25 to 50 mg	6 to 8 h

*If using an "off-label" drug, informed consent may be protective in cases where rare but possible side effects occur such as bleeding, pulmonary embolism, or continued pregnancy despite "prophylaxis." Informed consent ensures proper patient education has occurred and ensures that her values and ethics are taken into account in what may be a very emotionally charged decision.

**First dose should be taken as soon as possible, but minimally within 72 hours of the assault. Second dose should be taken12 hours after the first. If an anti-emetic is being used, it should be given 1 hour before the oral emergency pregnancy prevention tablets.

***Although commonly used "off-label," none of the above are FDA approved for post-coital pregnancy prophylaxis.

+Other medication may be equally effective.

++Dose may need to be altered based on patient age, weight or concurrent medications.

Source: Adapted from Trussell J, Koenig J, Ellertson C, et al: Preventing unintended pregnancy: The cost-effectiveness of three methods of emergency contraception. *Am J Public Health* 1997;87(6):932-937.

STEP 16 - PHOTOGRAPHS

Photographs are an important adjunct to the narrative information contained in the medical/forensic exam. Photographs serve to visually document the actual physical appearance of an injury to preserve it for additional analysis (i.e., a bite mark) and/or for presentation as evidence. For photographs to be admissible in court, they must first be authenticated. Someone who personally observed the patient's injuries must be able to testify that the photograph fairly and accurately depicts the actual appearance of the injury at the time the photograph was taken.

Photographs may only be taken with the written consent of the patient. Photographs should not be taken in the place of diagrams or written descriptions, and should be taken by the examiner. Only in cases where the examiner is unable to take photographs should other medical or law enforcement personnel who are trained to take photographs of injuries, be called in. **In addition, photographs taken in the context of the medical/forensic examination become part of the medical record**. They should be labeled, placed in the envelope provided, sealed and put in the medical record. **Photographs should <u>not</u> be placed in the evidence kit.** The existence of photographs should be noted on the Medical/Forensic Examination Form (Step 13).

Blank anatomical diagrams, which are provided in the kit, should be used to show the location and size of all visible injuries and should also be accompanied by a detailed written description of the trauma, including measurements of the injuries.

When photographs are taken, make sure to:

- Take a photograph of the injury with and without a color/measure standard, preferably the ABFO #2 (American Board of Forensic Odontology).
- Label each photograph with the patient's name, DOB, Medical Record Number, date and time of photograph, and signature of photographer. In instances where close-up photography is used, indicate the area of injury on the patient's body.
- Indicate on the body diagrams contained on Step 13 where the photographed injury is located and give a written description of the injury including size in the medical/forensic record
- Do not take genital photography without at minimum a macro instant camera, or a colposcope or its equivalent.
- **Re-photograph injuries when appropriate.** This will help to show the extent of the injuries, their severity and their healing over time.

Bite Mark Procedure

Bite marks may be found on patients as a result of sexual assault and other violent crime, and should not be overlooked as important evidence. Saliva, like semen, may demonstrate the DNA profile of the individual from whom it originated. Bite mark impressions can be compared with the teeth of a suspect and can sometimes become as important for identification purposes, as fingerprint evidence. The collection of saliva and the taking of a photograph of the affected area

are the minimum procedures that should be followed in cases where a bite mark is present, or believed to be present.

The collection of saliva from the bite mark should be made prior to the cleansing or dressing of any wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva.

It is important that photographs of bite marks be taken properly. An individual, deemed appropriate for the situation and who has sufficient photography skills, should be contacted immediately to take photographs of bite mark evidence utilizing an ABFO #2 standard.

Whenever possible, a dentist or a forensic odontologist should be called in to examine the bite mark and further document findings. Hospitals should contact the **New Hampshire Office of the Chief Medical Examiner** for a referral in locating a qualified forensic odontologist who can assist in this process. During normal business hours, call the office directly at **(603) 271-1235**. After hours, call **New Hampshire State Police Headquarters** at **(603) 271-3636** for assistance in reaching the Medical Examiner.

If the patient has not washed the area, and the bite mark occurred within 72 hours of the exam, saliva is collected from the bite mark area by moistening a sterile swab with a minimum of sterile water and gently swabbing the affected area, following the same procedures as instructed for other dried fluids.

STEP 17 – POST CARD MAILING

Every evidence collection kit contains a self-addressed, postage paid postcard. **The examiner is required to document the date of examination, the receiving police department, the serial number on the kit used for the exam and whether it was reported or anonymous.** The post card should then be put into the nearest mail system. The information contained on the card is being obtained for statistical purposes and it is very important that a post card is mailed for every kit that is used.

RELEASE OF EVIDENCE

All medical and forensic specimens collected during the sexual assault examination must be kept separate, both in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining hospital, and those required strictly for forensic analysis transferred with the evidence collection kit to the crime laboratory for analysis. When all evidence specimens have been collected, they should be placed back into the kit, making certain that everything is properly labeled and sealed. All unused envelopes should also be returned to the kit.

Under no circumstances should the patient be allowed to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from the hospital to the crime laboratory for analysis.

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult patient, or an authorized third party acting on the

patient's behalf, if the patient is unable to understand or execute the release. An *"Authorization for Release of Information and Evidence*" form should be completed, making certain that all items being transferred are checked off. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the examiner turning over the evidence, as well as from the law enforcement representative who picks up the evidence and transports it to the New Hampshire State Forensic Lab.

One copy of the release form should be kept at the hospital and the other copy returned to the kit.

All required information should then be filled out on the top of the kit just prior to sealing it with the provided red evidence tape at the indicated areas. Initial the evidence tape after sealing. The completed kit and clothing bags should be kept together and stored in a safe area**. Paper bags are to be placed next to, but not inside, the completed kit.**

Although the vast majority of sexual assault victims consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process; there may be instances when a patient will not authorize such a release. If consent is not initially received, an **Anonymous Sexual Assault Reporting System** is in place. All forms, as well as the kit box and clothing bags should be marked with the evidence collection kit serial number found on the end of the kit box, instead of the patient's name. **(See *Reporting Anonymously, page 14*)**

DISCHARGE OF THE PATIENT

COUNSELING

Since sexual assault is a violent crime, patients are often left feeling vulnerable, helpless, anxious, or phobic. Long-term counseling as well as short-term crisis intervention with a therapist or support organization may be needed to help the patient regain equilibrium.

Sexual Assault Crisis Centers offer peer support regarding the signs and symptoms of Rape Trauma Syndrome or Post Traumatic Stress Disorder and will also make referrals to a therapist upon request. The local crisis center should always be notified, and the list of crisis centers found inside the evidence collection kit should always be given to the patient. The examiner should determine whether immediate psychiatric consultation is necessary.

FOLLOW-UP CONTACT

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, patients should be asked before leaving the hospital whether they may be contacted about follow-up services. If so, they should be asked to provide an appropriate mailing address and/or telephone number where they can be reached.

Informational brochures on sexual assault and its aftermath are available from most sexual assault crisis centers. A copy should be provided to all victims and their families before they leave the hospital.

CHANGE OF CLOTHING

Many patients would like to wash after the examination and evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap, and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, **arrangements should be made to ensure that no patient has to leave the hospital in an examining gown.** Some patients may wish to have a family member or friend contacted to provide substitute clothing. When the patient has no available personal clothing, necessary items may be supplied by hospital volunteer organizations and/or local victim assistance agencies. Some crisis centers supply sweat suits for this purpose. The hospital should contact their local crisis center to arrange for clothing to be available.

TRANSPORTATION

Transportation should be arranged when the patient is ready to leave the hospital. In some cases, this will be provided by a family member, friend, or victim advocate who may have been called to the hospital for support. In other cases, transportation may be provided by the local police department as a community service.

PAYMENT FOR MEDICAL/FORENSIC EVALUATION

As of April 26, 1988, the State of New Hampshire is responsible for the payment of sexual assault medical/forensic examinations not covered by medical insurance or other third party payment when the examination is conducted for purposes that include collecting evidence. The following guidelines should be used in regards to hospital billing:

1. **The patient should never be billed**.

2. If the patient has health insurance, insurance information should be obtained by appropriate hospital personnel, and the insurance company should be billed directly for the cost of the examination. The patient should not be billed for anything above the coverage limit.

3. If the patient has no insurance, the Attorney General's Office should be billed directly.

4. In Anonymous Reporting Cases, all bills should be sent directly to the Attorney General's Office for payment. The patient's insurance should not be billed under any circumstances

As of 2002, the hospital payment for uninsured and anonymous reporting cases has been increased. It is imperative however that the hospital realizes that **reimbursement for the examination is based on the hospital adhering to the protocol.**

Bills should be submitted directly to the following address:

State Office of Victim/Witness Assistance
Attorney General's Office
33 Capitol Street
Concord, NH 03301
(603) 271-3671

APPENDICES

APPENDIX A

SEXUAL ASSAULT PROTOCOL/EVIDENCE COLLECTION KIT AND DOMESTIC VIOLENCE PROTOCOL STATUTE

NH RSA 21-M:8-c ***Victim of Alleged Sexual Offense***. If a physician or a hospital provides any physical examination of a victim of an alleged sexual offense to gather information and evidence of the alleged crime, these services shall be provided without charge to the individual. Upon submission of appropriate documentation, the physician or hospital shall be reimbursed for the cost of such examination by the Department of Justice to the extent such costs are not the responsibility of a third party under a health insurance policy or similar third party obligation. The bill for the medical examination of a sexual assault victim shall not be sent or given to the victim or the family of the victim. The privacy of the victim shall be maintained to the extent possible during third party billings. Billing forms shall be subject to the same principles of confidentiality applicable to any other medical record under RSA 151:13. Where such forms are released for statistical or accounting services, all personal identifying information shall be deleted from the forms prior to release.

21-M:8-d ***Standardized Rape Protocol and Kit and Domestic Violence Protocol***. The Department of Justice shall adopt, pursuant to RSA 541-A, and implement rules establishing a standardized rape protocol and kit and a domestic violence protocol to be used by all physicians or hospitals in this state when providing physical examinations of victims of alleged sexual offenses; and alleged domestic abuse, as defined in RSA 173-B:1.

APPENDIX B

NEW HAMPSHIRE SEXUAL ASSAULT CRISIS CENTERS

NEW HAMPSHIRE SEXUAL ASSAULT HOT-LINE: 1-800-277-5570

These centers provide the following free, confidential services to victims of sexual assaults:
*** 24 Hour Crisis Line Medical and Legal Options and Referrals Court Advocacy**
*** Peer Counseling and Support Groups Emotional Support**

RESPONSE to Sexual & Domestic Violence
C/o Coos County Family Health Service
54 Willow Street
Berlin, NH 03570
1-800-852-3388 (crisis line)
752-5679 (Berlin Office)
237-8746 (Colebrook Office)
788-2562 (Lancaster Office)

Women's Supportive Services
11 School Street
Claremont, NH 03743
1-800-639-3130 (crisis line)
543-0155 (Claremont Office)
863-4053 (Newport Office)

Rape and Domestic Violence Crisis Center
PO Box 1344
Concord, NH 03302-1344
1-800-277-5570 (SA crisis line)
1-866-644-3574 (DV crisis line)
225-7376 (0ffice)

Starting Point Services for Victims of Domestic and Sexual Violence
PO Box 1972
Conway, NH 03818
1-800-336-3795 (crisis line)
356-7993 (Conway Office)
539-5506 (Ossipee Office)

Women's Crisis Service of the Monadnock Region
12 Court Street
Keene, NH 03431-3402
352-3782 (crisis line)
352-3844 (Keene Office)
532-6800 (Jaffrey Office)

New Beginnings A Women's Crisis Center
PO Box 622
Laconia, NH 03246
1-800-277-5570 (SA crisis line)
1-866-644-3574 (DV crisis line)
528-6511 (Office)

Women's Information Services (WISE)
79 Hanover Street, Suite 1
Lebanon, NH 03766
448-5525 (crisis line)
448-5922 (Office)

The Support Center at Burch House
PO Box 965
Littleton, NH 03561
1-800-774-0544 (crisis line)
444-0624 (Littleton Office)
747-2441 (Woodsville Office)

YWCA Crisis Service
72 Concord Street
Manchester, NH 03101
668-2299 (crisis line)
625-5785 (Manchester Office)
432-2687 (Derry Office)

Bridges
PO Box 217
Nashua, NH 03061-0217
883-3044 (crisis line)
889-0858 (Nashua Office)
672-9833 (Milford Office)

Voices Against Violence
PO Box 53
Plymouth, NH 03264
536-1659 (crisis line)
536-3423 (Office)

Sexual Harassment and Rape Prevention Program (SHARPP)
UNH
12 Ballard Street
Durham, NH 03824
862-3494 (Office)
862-SAFE (7233) (crisis line)
1-866-233-SAFE (7233) (Toll free crisis line)

A Safe Place
PO Box 674
Portsmouth, NH 0302
4366-7924 (Portsmouth crisis line)
436-4619 (Portsmouth Office)
330-0214 (Rochester crisis line)
890-6392 (Salem crisis line)

Sexual Assault Support Services
7 Junkins Avenue
Portsmouth, NH 03801
1-888-747-7070 (crisis-toll free)
436-4107 (Portsmouth Office)
332-0775 (Rochester Office)

APPENDIX C

NEW HAMPSHIRE VICTIM/WITNESS ASSISTANCE PROGRAMS

State Office of Victim/Witness Assistance
Attorney General's Office
33 Capitol Street
Concord, NH 03301
271-3671

Belknap County Victim/Witness Program
Belknap County Superior Courthouse
64 Court Street
Laconia, NH 03246
524-8050

Carroll County Victim/Witness Program
P.O. Box 218
Ossipee, NH 03864
539-7769

Cheshire County Victim/Witness Program
P.O. Box 612
Keene, NH 03431
352-0056

Coos County Victim/Witness Program
149 Main Street
P.O. Box 366
Lancaster, NH 03584
788-3812

Grafton County Victim/Witness Program
3801 Dartmouth College Highway
No. Haverhill, NH 03774
787-2193

Hillsborough County Victim/Witness Program
300 Chestnut Street
Manchester, NH 03101
627-5605

Hillsborough County Attorney's Office
Southern District
Victim Witness Program
19 Temple Street
Nashua, NH 03060
594-3256

Merrimack County Victim/Witness Program
4 Court Street
Concord, NH 03301
228-0529

Rockingham County Victim/Witness Program
P.O. Box 1209
Kingston, NH 03848
642-4249

Strafford County Victim/Witness Program
P.O. Box 799
Dover, NH 03821-0799
749-4215

Sullivan County Victim/Witness Program
Sullivan County Attorney's Office
14 Main Street
Newport, NH 03773
863-8345

United States Attorney's Office
District of New Hampshire
James C. Cleveland Federal Bldg.
55 Pleasant St., Suite 312
Concord, NH 03301
225-1552

APPENDIX D

STI CLINICS AND HIV COUNSELING AND TESTING SITES

BERLIN
COOS COUNTY FAMILY
HEALTH SERVICES
54 Willow Street
Berlin, NH 03570
(603) 752-2040

CLAREMONT
PLANNED PARENTHOOD
5 Dunning Street
Claremont, NH 03743
(603) 542-4568

CONCORD
CAPITOL REGION FAMILY
HEALTH CENTER
250 Pleasant Street
Concord, NH 03301
(603) 225-5567

CONWAY
WHITE MOUNTAIN
COMMUNITY
HEALTH CENTER
P.O. Box 20800
258 White Mountain Highway
Conway, NH 03818
(603) 447-8900

DOVER
AVIS GOODWIN
COMMUNITY
HEALTH CENTER, Doctors
Park II
19 Old Rollinsford Road
Dover, NH 03820
(603) 749-2346

FRANKLIN
FRANKLIN FAMILY
PLANNING
841 Central Street
Franklin, NH 03235
(603) 934-4905

GREENLAND
FEMINIST HEALTH CENTER
OF PORTSMOUTH
P.O. Box 456
559 Portsmouth Avenue
Greenland, NH 03840
(603) 436-7588

KEENE
PLANNED PARENTHOO
NNE
8 Middle Street
Keene, NH 03431
(800) 352-6898

LEBANON
DARTMOUTH HITCHCOCK
INFECTIOUS DISEASE
SECTION
1 Medical Center Drive
Lebanon, NH 03756
(603) 650-6060

LACONIA
LACONIA FAMILY
PLANNING
121 Belmont Road
Laconia, NH 03246
(603) 524-5453

LITTLETON
AMMONOOSUC
COMMUNITY HEALTH
SERVICES
25 Mount Eustis Road
Littleton, NH 03561
(603) 444-2464

MANCHESTER
MANCHESTER HEALTH
DEPT.
1528 ELM STREET
Manchester, NH 03101
(603) 624-6466

NASHUA
COMMUNITY HEALTH
DEPT.
18 MULBERRY STREET
Nashua, NH 03060
(603) 589-4500

PLYMOUTH
FAMILY PLANNING
WHOLE VILLAGE
RESOURCE
258 Highland Street
Phymouth, NH 03264
(603) 536-3584

PORTSMOUTH (See Greenland)

ROCHESTER
AVIS GOODWIN
COMMUNITY HEALTH
CENTER
22 South Main Street
Rochester, NH 03867
(603) 332-4249

APPENDIX E

DRUG-FACILITATED SEXUAL ASSAULT

National Criminal Justice Research Service (NCJRS): In the spotlight: Club drugs
http://www.ncjrs.org/club_drugs/summary.html

National Institute on Drug Abuse: Club drugs
http://www.nida.nih.gov/Infofax/clubdrugs.html

Office of National Drug Control Policy (ONDCP): Club drugs
http://www.whitehousedrugpolicy.gov/drugfact/club/index.html

United States Department of Justice: Information Bulletin: Raves
http://www.usdoj.gov/ndic/pubs/656/

United States Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol & Drug Information:
Rohypnol Fact Sheet
http://www.health.org/nongovpubs/rohypnol/
GHB Fact Sheet
http://www.health.org/nongovpubs/ghbqa/
MDMA/Ecstasy Fact Sheet
http://store.health.org/catalog/facts.aspx?topic=4&h=drugs
Others
http://www.health.org/newsroom/abuseInformation/default.aspx?s=oxycontin

The National Women's Health Information Center: Date rape drugs
http://www.4woman.gov/faq/rohypnol.htm

US Department of Justice Federal Bureau of Investigation. LeBeau MA. Toxicological Investigation of Drug-Facilitated Sexual Assault. Forensic Science Communications. 1999 Apr; 1(1)
http://www.fbi.gov/hq/lab/fsc/backissu/april1999/lebeau.htm

Sexual Assault Training & Investigations
http://www.mysati.com/resources_new.htm

American Prosecutor's Research Institute: The Prosecution of Rohypnol and GHB-related sexual assaults
http://www.ndaa-apri.org/publications/apri/violence_against_women.html

Project GHB, Inc.
http://www.projectghb.org/

Toxicity: Gamma-Hydroxybuterate (article)
http://emedicine.com/emerg/topic848.htm

APPENDIX F

CHILD ABUSE AND NEGLECT MANDATORY REPORTING LAW

l. Reporting is Mandatory

New Hampshire Law (RSA l69-C:29-30) requires that any person who has reason to suspect that a child under the age of l8 has been abused or neglected must report the case to: **The Local District Office New Hampshire Division of Welfare**

II. An Abused Child is one who has:

A. Been sexually molested; or
B. Been sexually exploited; or
C. Been intentionally physically injured; or
D. Been psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect; or
E. Been physically injured by other than accidental means.

III. A Neglected Child means a child:

A. Who has been abandoned by his parents, guardian, or custodian; or
B. Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental or emotional health, when it is established that his health has suffered or is very likely to suffer serious impairment; and the deprivation is not due primarily to the lack of financial means of the parents, guardian or custodian; or
C. Whose parents, guardian or custodian are unable to discharge their responsibilities to and for the child because of incarceration, hospitalization or other physical or mental incapacity.

Note: A child who is under treatment solely by spiritual means through prayer, in accordance with the tenets of a recognized religion by a duly accredited practitioner thereof, shall not for that reason alone be considered to be neglected.

IV. Nature and Content of Report

A. Oral - immediately by telephone or otherwise.
B. Written - within 48 hours if requested.
C. Content - if known.
    l. Name and address of the child suspected of being neglected or abused.
    2. Name of parents or persons caring for child.
    3. Specific information indicating neglect or the nature of the abuse (including any evidence of previous injuries).
    4. Identity of parents or persons suspected of being responsible for such neglect or abuse.
    5. Any other information, which might be helpful or is required by the bureau.

V. Immunity from Liability

Anyone who makes a report in good faith is immune from any liability, civil or criminal. The same immunity applies to participation in any investigation by the bureau or judicial proceedings resulting from such a report.

VI. Privileged Communication

"The privileged quality of communication between a professional person and his patient or client, except that between attorney and client, shall not apply to proceedings instituted pursuant to this chapter and shall not constitute grounds for failure to report as required by this chapter."

VII. Penalty

Violation of any part of the New Hampshire Child Protection Act, including failure to report is punishable by law. "Anyone who knowingly violates any provision of this subdivision shall be guilty of a misdemeanor." (RSA l69-C:39.) In New Hampshire, a misdemeanor is punishable by up to one year's imprisonment, a one thousand-dollar fine, or both.

APPENDIX G

NEW HAMPSHIRE DIVISION OF ELDERLY AND ADULT SERVICES DISTRICT OFFICES

Berlin District Office
219 Main Street
Berlin, NH 03570-1720
603-752-7800
1-800-972-6111

Claremont District Office
17 Water Street
Claremont, NH 03743-2280
603-542-9544 or
1-800-982-1001

Concord District Office
40 Terrill Park Drive
Concord, NH 03301-7825
603-271-3610 or
1-800-322-8191

Conway District Office
73 Hobbs Street
Conway, NH 03818
603-447-3841 or
1-800-552-4828

Keene District Office
809 Court Street
Keene, NH 03431-1712
603-357-3510 or
1-800-624-9700

Laconia District Office
65 Beacon Street West
Laconia, NH 03246
603-524-4485 or
1-800-322-2181

Littleton District Office
80 N. Littleton Road
Littleton, NH 03561
603-444-6786
1-800-552-8959

Manchester District Office
351 Lincoln Street
Manchester, NH 03103-4976
603-668-2330 or
1-800-852-7493

Nashua District Office
19 Chestnut Street
Nashua, NH 03060
603-863-7726 or
1-800-852-0632

Portsmouth District Office
30 Maplewood Avenue
Portsmouth, NH 03801-3737
603-433-8318 or
1-800-821-0326

Rochester District Office
150 Wakefield Street
Rochester, NH 03867
603-332-9120 or
1-800-862-5300

Salem District Office
154 Main Street
Salem, NH 03079-3191
603-893-9763 or
1-800-852-7492

If you are unable to reach the appropriate District Office indicated above, contact the following:

New Hampshire Division of Elderly and Adult Services
State Office Park South
113 Pleasant Street
Annex Bldg. #1
Concord, NH 03301-3843
603-271-7014 or
1-800-852-3345 Ext. 4386
TDD Access: Relay NH 1-800-735-2964

APPENDIX H

MEDICAL/FORENSIC WEB LINKS

Centers for Disease Control
www.cdc.gov

American College of Emergency Physicians
www.acep.org

International Association of Forensic Nursing
www.iafn.org

American Medical Association
Treatment Guidelines on Violence
Ordering information
http://www.ama-assn.org/ama/pub/category/3548.html

APRI--American Prosecutors Research Institute-Violence Against Women Unit
http://www.ndaa-apri.org/apri/Vawa/Index.html

Forensic Associations
http://www.forensiceducation.com/assn.htm

Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims
http://www.ojp.usdoj.gov/ovc/publications/bulletins/sane_4_2001/welcome.html

Sexual Assault Resource Service
Includes downloadable version of Linda Ledray's SANE Guide.
http://www.sane-sart.com

Understanding DNA Evidence: A Guide for Victim Service Providers
http://www.ojp.usdoj.gov/ovc/publications/bulletins/dna_4_2001/welcome.html